APPLICATION TO BECOME A LEAVE RECIPIENT

Proponent - DRM; Directive - FLW CPR 690-12

In accordance with the Voluntary Leave Transfer Program, I request to be a leave recipient under the program. The following information is provided:

Name:	Employing Activity:
Position Title, Grade and Step:	Duty Phone:

DETAILED AND SPECIFIC DESCRIPTION of the nature of the medical emergency, including medical documentation, if appropriate:

Date Personal Emergency Began (If surgery, state date of surgery):

Anticipated Duration:

If recurring, the approximate frequency of the medical emergency:

Annual leave balance _____ hours as of _____

Sick leave balance _____ hours as of _____

Copy of latest DA Form 4536, Earnings and Leave Statement (or MyPay printout) must be attached.

I have ☐ I have not ☐ requested advanced sick leave.

SUPERVISORY COORDINATION AND RECOMMENDED ACTION

Name and Title:	☐ Approve	☐ Disapprove
Name and Title:	☐ Approve	☐ Disapprove
Name and Title:	☐ Approve	☐ Disapprove

APPROVING OFFICIAL

Name and Title:	Date:	☐ Approve ☐ Disapprove

If form is not completely filled out, it will be returned without action for applicant to complete.

FLW Form 464 (Rev Dec 02) Previous Edition Obsolete